PRINTED: 08/01/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G593		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 06/22/2012		
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE  3142 62ND PL E  HOBART, IN 46342				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
W0000	complaint #IN00 COMPLAINT # SUBSTANTIAT deficiencies rela cited at W122, W W156.  Dates of Survey 2012  Facility number Provider numbe AIM number: 1 Surveyor: Chris Surveyor III/QM The following for reflect state find 460 IAC 9.	FIN00109706: FED, federal and state ted to the allegation are W149, W153, W154 and  7: June 20, 21 and 22,  1: 001107  1: 15G593  1: 00245570  1: otine Colon, Medical MRP  1: dederal deficiencies also ings in accordance with  1: mpleted 6/29/12 by Ruth	WO	000	Refer to W122, W149, W153 W154 and W156.	3,	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	SUILDING 00		COMPLETED	
		15G593	A. BUII B. WIN			06/22/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				2ND PL E		
REM_INIT	DIANA INC				RT, IN 46342		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0122	483.420						
	CLIENT PROTE						
		ensure that specific client					
	i '	rements are met.	1110	100			07/12/2012
	Based on record	review and interview, the	W0	122	The facility currently has a writ	ten	07/13/2012
	Condition of Par	ticipation, Client			policy and procedure on mistreatment, neglect or abuse	o of	
	Protections, is no	ot met as the facility			a client and the reporting there		
		itten documentation to			All new employees are trained		
		gh investigation of an			the policy and procedure for	J.,	
		se was completed for 1			reporting injury of the clients to	)	
	_	-			the proper authorities within ar		
		n reviewed involving 1 of			outside the agency. The facility	y	
	4 sampled clients	s (client A).			follows a protocol including		
					assessment of client behavior	-	
	Findings include	:			support plans, program goals a		
					individual support plan to ensu		
	1. Please refer to	W149. The facility			the client needs and protection	1	
		ent their abuse/neglect			met. The facility will retrain the staff on endangered adults,		
		npleting a thorough			supervision of clients, witten		
	1				policy and procedure on		
	_	1 of 1 investigation			mistreatment, neglect or abuse	e of	
	reviewed of an al	llegation of staff abuse			a client and the reporting plan		
	involving 1 of 4	sampled clients (client			and protocols to ensure full		
	A).				measures are being employed	to	
					protect the clients. The Home		
	2 Please refer to	W153. The facility			manager and Program Directo		
		•			will each complete observation		
		investigation of alleged			the home weekly for 30 days to	0	
		lving 1 of 4 sampled			ensure the staff are reporting		
	clients (client A)	, to report immediately to			incidents and following policy t protect the clients. The Program		
	the administrator	and to the Bureau of			Director will monitior the staff a		
	Developmental I	Disabilities Services			documentation logs to ensure		
	_	dance with state law.			incidents that occur are		
		anico mini biato iaw.			addressed to ensure the client	's	
	2 Dlagge C. 4	W154 The Co. 114			basic needs are being met in f		
		W154. The facility			The facility will continue to train		
		investigation of alleged			employees to follow the report		
	staff abuse, invol	lving 1 of 4 sampled			guidelines of behavior plans as		
	clients (client A)	, to provide evidence a			written and initiation of behavio	oral	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G593		A. BUILDING  B. WING			COMPLETED 06/22/2012		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  3142 62ND PL E  HOBART, IN 46342				
(X4) ID PREFIX TAG	summary structure (EACH DEFICIENCE REGULATORY OR thorough investign 4. Please refer to failed to report the reviewed investign sampled clients (administrator with the summary of the summ	ratement of deficiencies CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  gation was completed.  O W156 as the facility he results of 1 of 1 gation, involving 1 of 4 client A), to the chin five business days.  grelates to complaint		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  intervention techniques as trained. In the future, the Home Manager will conduct weekly observations of the home and staff to ensure protocols are being followed and clients are protected. The Progran Direct will report to all parties internal and outside agencies of any alleged abuse or neglect. The program Director will begin an investigation upon receipt of sa allegation within 5 days.Person reponsibile: Area DirectorCompletion Date: 07/22/2012	e or ly	(X5) COMPLETION DATE

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Event ID: WD7211

Facility ID: 001107

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G593	B. WING		06/22/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R		2ND PL E	
REM-IND	DIANA INC			RT, IN 46342	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
W0149	The facility mus written policies a mistreatment, no	MENT OF CLIENTS t develop and implement and procedures that prohibit eglect or abuse of the client. I review and interview, the	W0149	The facility currently has a witt	ten 07/13/2012
	facility failed to	implement their		policy and procedure on mistreatment, neglect or abuse	o of
	abuse/neglect po	olicy by not completing a		a client and the reporting there	
	thorough investi	igation of an allegation of		All new employees are trained	
	staff abuse for 1	of 1 investigation		the policy and the procedure for	
		ring 1 of 4 sampled clients		reporting injury of the clients to	
	(client A).			the proper authorities within a	
	(chefit 11).			outside the agency. The facitly	′
	Findings include	a·		follows a protocol including assessment of client behaviors	
	1 manigs merado			support plans, program goals	
	A rayiayy of the	facility's investigation		individual support plan to ensu	
		facility's investigation		the client needs and protection	
		ducted on 6/21/12 at 2:45		met.The facility will retrain the	
		of the facility's records		staff on endangered adults,	
	indicated:			supervision of clients, written	
				policy and procedure on mistreatment, neglect or abuse	e of
	"'Summary of Ir	nternal Investigation		a client and the reporting plan	
	Report' dated 6/	14/12Re: Allegation of		and protocols to ensure full	
	physical abuse	.Date of Incident: 6/7/12:		measures are being employed	l to
		Staff (DSP) #1 reported on		protect the clients. The Home	
		ne Manager (HM) that		manager and Program Directo	
		apped [client A] in the		will each complete observation	
		spit in [DSP #2]'s face.		in the home weekly for 30 day ensure the staff are reporting	5 10
		aspended on 6/7/12. [DSP		incidents and following policy	to
		•		protect the clients.The Prograi	
		led on 6/7/2012Dates of		Director will monitor the staff a	
	_	/8/12, 6/11/12, 6/13/12,		documentation logs to ensure	that
	6/14/12 and 6/15	5/12."		incidents that occur are	de l
				addressed to ensure the client basic needs are being met in f	
	DSP #1 intervie	w:		The facility will continue to trai	
				employees to follow the report	
	"[DSP #1] stated	d they were at [Group		guidelines of behavior plans a	•

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G593		A. BUILDING  B. WING	COMPLETED 06/22/2012			
	PROVIDER OR SUPPLIER DIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE  3142 62ND PL E  HOBART, IN 46342				
		ID PREFIX TAG  PROVIDERS PLAN OF CORRESPENCY  Written and initiation of beinterventions techniques trained. In the future, the Manager will conduct we observations of the hom staff to ensure protocols being followed and clien protected. The Program will begin an investigation receipt of said allegation complete within 5 days. addition to the Area Director and the Program Director and the Program Director and the Program of the Program of the Program Director and the Program Director and the Program of the Progr	COMPLETION DATE  COMPLETION DATE  DATE  COMPLETION DATE			
	sitting with [client Z] on Friday and [HM					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G593		A. BUILDI		00	(X3) DATE COMPL 06/22/	ETED	
	PROVIDER OR SUPPLIER		B. WING GOZZZZGTZ  STREET ADDRESS, CITY, STATE, ZIP CODE  3142 62ND PL E  HOBART, IN 46342				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)		ATE	(X5) COMPLETION DATE
	#1] asked her did #2] and [client Z] stated [DSP #2]; demonstrated wi asked [client Z] I [client Z] stated; with [DSP #1].   [DSP #1] was he and stated she wi of [DSP #1]'s var [client A]."  DSP #3 interview  "[DSP #3] stated abuse but had no Examples were i go with [DSP #2 would increase. [DSP #2] nit pick  Further review o indicated the foll  "Also during the was noted that st been involved at allegations of an moved to day pro-	I she feel afraid of [DSP] said yes. [HM #1] pointed at [client A] and the her hands. [HM #1] how did she know and she saw when she was [Client Z] reported that it staff the day in question as sitting in the front seat in when [DSP #2] slapped  v:  she had a feeling of concrete evidence. Individuals didn't want to [DSP #3] stated she saw king with other clients."  If the investigation record owing:  documentation review it aff person [DSP #2] has the minimum of 3 abuse other client and was ogram for her protection."					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			
		15G593	B. WING		06/22/2012	
NAME OF	PROVIDER OR SUPPLIE	ER.		ADDRESS, CITY, STATE, ZIP CODE		
	DIANIA INIO			2ND PL E		
	DIANA INC		HOBAI	RT, IN 46342		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
1710	+	shook his head indicating	1710	<u> </u>	DATE	
		ed if [DSP #2] slapped				
	1 *	[client A] shook his head				
	1	nd then pointed to his right				
	_	asked if [DSP #2]				
		d, [client A] shook his				
	~	yes and then grabbed his				
		th his left hand and began				
	bending them b	•				
	bending them b	ackwaius.				
	Δ request for in	vestigation records				
	1 ^	#2 was made on 6/22/12 at				
		n investigation record				
		from the facility's				
		g site was submitted for				
	* *	A.M Review of the				
		d [DSP #2] was accused of				
		ortive living client while				
		eeding the client. The				
		Freported she did not				
	_	port the incident because				
	1	ned by [DSP #2].				
	she left threaten	ica oy [DSI 112].				
	A review of the	facility's "Supervised				
		olicy Manual: Human				
		/10/06 was conducted at				
	_	ministrative office on				
	_	A.M Review of the				
		indicated: "Ensure clients				
		d to physical abuseare				
		essary restraintsThe				
		ns are prohibited by				
ĺ		ndiana Mentor: abuse,				
		ation or mistreatment of				
	"", "", "", ""					

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PRINTED: 08/01/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION  OF CORRECTION  15G593	(X2) MULTIPLE CO A. BUILDING B. WING	00	CON	TE SURVEY MPLETED 22/2012		
	PROVIDER OR SUPPLIER DIANA INC	STREET ADDRESS, CITY, STATE, ZIP CODE  3142 62ND PL E  HOBART, IN 46342					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	an individualAny allegation of abuse or human rights violation is thoroughly investigated by the Director of Program Services in consultation with the Human Resources Department and/or Risk Management Department."						
	An interview with Program Director (PD) #2 was interviewed on 6/22/12 at 9:40 A.M PD #2 indicated the investigation into the 6/7/12 abuse allegation involving client A and results of an investigation were not complete yet. PD #2 stated "I submitted my report to the Area Director and she submitted her report to her supervisor and currently it is in Quality Assurance (QA). It still has to go to the QA supervisor, then to the administrator and then her supervisor."						
	This federal tag relates to complaint #IN00109706. 9-3-2(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLE			ETED	
		15G593	B. WIN			06/22/	2012
(F. 6F. F				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	-		3142 62	2ND PL E		
	DIANA INC				RT, IN 46342		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
		LSC IDENTIFYING INFORMATION)		IAG	DEFICIENCE		DATE
TAG W0153	483.420(d)(2) STAFF TREATM The facility must mistreatment, ne injuries of unknow immediately to the officials in accord established proces  Based on record facility failed for involving 1 of 4 standards A), to report an a abuse immediate and to the Bureau Disabilities Servit accordance with  Findings include  A review of the frecords was cond P.M Review of indicated:  ""Summary of Int Report' dated 6/1 physical abuse	review and interview, the 1 of 1 allegation sampled clients (client allegation of physical ly to the administrator at of Developmental fices (BDDS) in state law.	W0	153	The facility currently has a writt policy and procedure on mistreatment, neglect or abuse a client and the reporting there All new employees are trained the policy and the procedure for reporting injury of the clients to the proper authorities within aroutside the agency. The Home manager will retrain the staff the adhere to the reporting guidelity of reporting an incident of potential abuse or neglect of a client to ensure investigation of such incident is engaged to begin an investigation and in addition reported within 24 hours as mandated. The Home Manawill monitor the daily support records and behavior support data daily to ensure client incidenter reported to the Program Director. Program Director will monitor the staff and documentation logs weekly to ensure that incidents that occurare reported in a timely manner the future. Person Responsibility Area Director Completeion:	e of e of. on or on do nes f urs ger dent	DATE 07/13/2012
	suspended on 6/7	n 6/7/12. DSP #1 was 7/2012Dates of 8/12, 6/11/12, 6/13/12,					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G593		A. BUILDING  B. WING			COMPLETED 06/22/2012				
	PROVIDER OR SUPPLIER		p. wax	STREET ADDRESS, CITY, STATE, ZIP CODE  3142 62ND PL E  HOBART, IN 46342					
	SUMMARY ST (EACH DEFICIENCE REGULATORY OR  6/14/12 and 6/15  An interview was  Program Director  administrative of  A.M The PD in  occurred the wee  not reported to th  The PD stated "In  reported immedia  and within 24 ho	ratement of deficiencies cy must be perceded by full LSC IDENTIFYING INFORMATION)  /12."  s conducted with the r (PD) at the facility's fice on 6/22/12 at 9:40 adicated the incident k prior to 6/7/12 but was a facility until 6/7/12. Incidents are to be ately to the administrator		3142 62	ND PL E	TE.	(X5) COMPLETION DATE		

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
	15G593	B. WING		06/22/2012	
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE		
			2ND PL E		
REM-INI	DIANA INC	HOBAF	RT, IN 46342		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
W0154	483.420(d)(3) STAFF TREATMENT OF CLIENTS				
	The facility must have evidence that all				
	alleged violations are thoroughly investigated.				
		W0154	The facility currently has a wr	itten 07/13/2012	
	Based on record review and interview, the		policy and procedure in place		
	facility failed for 1 of 1 investigation of		mistreatment, neglect or abus		
	alleged staff abuse, involving 1 of 4		a client and the reporting ther		
	sampled clients (client A), to provide		All new employees are trained the policy and the procedure		
	evidence a thorough investigation was		reporting injury of the clients t		
			the proper authorities within a		
	completed.		e		
Findings include:	Findings include:		Manager will retrain the staff		
	Findings include.		adhere to the reporting guidely of reporting an incident of	ines	
	A review of the facility's investigation		potential abuseor neglect of a	ı	
	records was conducted on 6/21/12 at 2:45		client to ensure investigation	of	
	P.M Review of the facility's records		such incident is engaged to		
	indicated:		begin an investigation and in addition reported within 24hor	ure	
	indicated.		as mandated.The Home Man		
	"Summary of Internal Investigation		will monitor the daily support		
	Report' dated 6/14/12Re: Allegation of		record and behavior support		
	physical abuseDate of Incident: 6/7/12:		daily to ensure client incidents		
	Direct Support Staff (DSP) #1 reported on		reported to the Program Director will monitor		
			staff and documentation logs		
	6/7/2012 to Home Manager (HM) that		weekly to ensure that inciden	ts	
	[DSP #2] had slapped [client A] in the		that occur are reported in a til	mely	
	face because he spit in [DSP #2]'s face. [		manner in the future.Person		
	DSP #2] was suspended on 6/7/12. [DSP		Responsible: Area DirectorCompletion Date:		
	#1] was suspended on 6/7/2012Dates of		07/22/2012		
	investigation: 6/8/12, 6/11/12, 6/13/12,				
	6/14/12 and 6/15/12."				
	DSP #1 interview:				
	"[DSP #1] stated they were at [Group				
	Home name]. [DSP #1] was not able to				

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` ′			(X2) MULTI	IPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	00	COMPL	ETED	
		15G593	B. WING	-		06/22/	2012	
			ST	TREET A	DDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIE	К	3142 62ND PL E					
REM-IND	DIANA INC		Н	HOBART, IN 46342				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	II	)	NO CAMPANA NA LAY OR GONDAGOWANA		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TA	4G	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE	
	provide a date as	s to when this happened.						
	[DSP #1] stated	that this happened about						
	a week ago. [Cl	ient A] was the only one						
	in the car when	she heard [client A] yell.						
	[DSP #1] stated	she made it to the						
	passenger side o	of [DSP #2]'s car door and						
		t A] spit in [DSP #2]'s						
	_	stated [DSP #2] slapped						
		ated you are not going to						
		what I told you about that.						
	[ DSP #1] stated [client A] started pulling							
		nirt. [DSP #1] stated						
		client A]'s fingers and						
		to hurt him. [DSP #1]						
		walked up to her later						
		petter not find out [DSP						
	#1] told anyone.	<del>-</del>						
	" I told unyone.							
	Home Manager	#1 interview:						
		she and [DSP #1] were						
	_	on June 7, 2012 and						
		she didn't want to come						
		w. [HM #1] stated [DSP						
	_	at about coming to work						
	because of [DSF	P #2]. [HM #1] stated						
	[DSP #1] stated	she saw [DSP #2] slap						
	[client A] in the	face one day last week						
	because he spit	on her. [HM #1] stated						
	[DSP #1] stated	she really think (sic)						
	[DSP #2] is goir	ng to hurt one of the						
	individuals. [H]	M #1] stated she was						
	sitting with [clie	ent Z] on Friday and [HM						
	#1] asked her di	d she feel afraid of [DSP						
	I .						l .	

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G593		A. BUILI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 06/22/2012	
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE  3142 62ND PL E  HOBART, IN 46342					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE	
TAG	#2] and [client Z] stated [client Z]; stated [DSP #2]; demonstrated wi asked [client Z] I [client Z] stated with [DSP #1]. [DSP #1] was he and stated she with [DSP #1]'s var [client A]."  DSP #3 interview "[DSP #3] stated abuse but had no	said yes. [HM #1] pointed at [client A] and slapped [client A] and th her hands. [HM #1] how did she know and she saw when she was [Client Z] reported that r staff the day in question as sitting in the front seat n when [DSP #2] slapped  v: she had a feeling of concrete evidence.		TAG	DEFICIENCY)		DATE	
	go with [DSP #2 would increase. [DSP #2] nit pick	ndividuals didn't want to  ]. Client behaviors  [DSP #3] stated she saw king with other clients."  f the investigation record						
	was noted that st been involved at allegations of an	documentation review it aff person [DSP #2] has the minimum of 3 abuse other client and was ogram for her protection."						
	When asked if he	th [client A] was 22/12 at 8:30 A.M the knew who [DSP #2] thook his head indicating						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G593  NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC  IDENTIFICATION NUMBER: A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3142 62ND PL E	(X5)
NAME OF PROVIDER OR SUPPLIER  3142 62ND PL E	(X5)
REM-INDIANA INC HOBART, IN 46342	(X5)
	(X5)
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	
CROSS-REFERENCED TO THE APPROPRIATE	MPLETION
THE REGULATORY OF ESCHELLING THE ORIGINATION)	DATE
yes. When asked if [DSP #2] slapped him in the face, [client A] shook his head	
indicating no and then pointed to his right	
forearm. When asked if [DSP #2]	
grabbed his hand, [client A] shook his	
head indicating yes and then grabbed his	
right fingers with his left hand and began	
bending them backwards.	
A request for investigation records	
involving DSP #2 was made on 6/22/12 at	
10:00 A.M An investigation record dated 12/15/11, from the facility's	
supportive living site was submitted for	
review at 11:00 A.M Review of the	
record indicated [DSP #2] was accused of	
slapping a supportive living client while	
[DSP #2] was feeding the client. The	
witnessing staff reported she did not	
immediately report the incident because	
she felt threatened by [DSP #2].	
An interview with Program Director (PD)	
#2 was interviewed on 6/22/12 at 9:40	
A.M. PD #2 indicated the investigation into the 6/7/12 abuse allegation involving	
client A and results of an investigation	
were not complete yet. PD #2 stated "I	
submitted my report to the Area Director	
and she submitted her report to her	
supervisor and currently it is in Quality	
Assurance (QA). It still has to go to the	
QA supervisor, then to the administrator	
and then her supervisor."	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G593		A. BUILDING B. WING	00	COMPLETED 06/22/2012				
NAME OF PROVIDER OR SUPPLIER  REM-INDIANA INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3142 62ND PL E HOBART, IN 46342					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	This federal tag #IN00109706. 9-3-2(a)	relates to complaints						

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Event ID: WD7211

Facility ID: 001107

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED		
	15G593		B. WING			06/22/2012	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER							
REM-INDIANA INC				3142 62ND PL E HOBART, IN 46342			
				HODAN			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL					COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
W0156	483.420(d)(4) STAFF TREATM The results of all reported to the arepresentative or accordance with days of the incide Based on record facility failed to a 1 reviewed invess sampled clients (administrator with Findings included A review of the forecords was conditioned by the following of the following facility failed to a 1 reviewed invess sampled clients (administrator with Findings included by the following facility failed for the following failed for the failed failed failed failed for the failed f	IENT OF CLIENTS investigations must be dministrator or designated r to other officials in State law within five working ent. review and interview, the report the results of 1 of digation, involving 1 of 4 fclient A), to the thin five business days.  :  Facility's investigation ducted on 6/21/12 at 2:45 f the facility's records  ternal Investigation 4/12Re: Allegation of Date of Incident: 6/7/12: taff (DSP) #1 reported on the Manager (HM) that ped [client A] in the face on DSP #2's face. DSP #2 on 6/7/12. DSP #1 was of 1/2012Dates of	W0		The facility currently has a writte policy and procedure on mistreatment, neglect or abuse a client and the reporting there of. All new employees are train on the policy and the procedur for reporting injury of the client the proper authorities within an outside the agency. The Home Manager will retrain the staff to adhere to the reporting guideling of reporting an incident of potential abuse or neglect of a client to ensure investigation of such incident is engaged to be an investigation and in addition reported within 24hours as mandated. The Home Manager will monitor the daily support records and behavior support data daily to ensure client incidents are reported to the Program Director. Program Director will monitor the staff a documentaion logs weekly to ensure that incidents that occur are reported in a timely manner the future. In addition the Area Director will retrain the Program Director on reporting timeframe in order to meet process deadlines. Person Responsible Area DirectorCompletion Date	e of ened ened es to and ones figin on the ened enes ened enes enes enes enes ene	07/13/2012
	indicate findings	-			Area DirectorCompletion Date 07/22/2012	:	

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15G593 B. WING		06/22/2042			
		06/22/2012			
REM-INDIANA INC  3142 62 HOBAF	STREET ADDRESS, CITY, STATE, ZIP CODE  3142 62ND PL E  HOBART, IN 46342				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID  PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX  TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
were forwarded to the facility's administrator within five working days.					
An interview with Program Director (PD) #2 was interviewed on 6/22/12 at 9:40 A.M PD #2 indicated the investigation into the 6/7/12 abuse allegation involving client A and results of the investigation were not forwarded to the administrator. PD #2 stated "I submitted my report to the Area Director and she submitted her report to her supervisor and currently it is in Quality Assurance (QA). It still has to go to the QA supervisor and then to the administrator."  This federal tag relates to complaint #IN00109706.  9-3-2(a)					

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